Core Services Taxonomy 7

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Introduction

The idea of core services emerged from the General Assembly's Commission on Mental Health and Mental Retardation in 1980. The first list of core services, developed in response to a Commission recommendation, contained five categories of services: emergency, inpatient, outpatient and day support, residential, and prevention and early intervention. The State Mental Health, Mental Retardation and Substance Abuse Services Board (State Board) approved the original core services definitions in 1981. The General Assembly accepted general definitions of these services and amended § 37.1-194 of the *Code of Virginia* in 1984 to list the services. That section required only the provision of emergency services; other services were not mandated. In 1998, the General Assembly added a second mandated service, case management, but qualified the requirement with this condition, " . . . case management services subject to such funds as may be appropriated therefor, . . ."

The initial description of core services established a useful conceptual framework for Virginia's network of community and state facility services. However, it was too general and not sufficiently quantifiable for meaningful data collection and analysis. The initiation of performance contracting in Fiscal Year (FY) 1985 revealed the need for detailed, consistent, and measurable information about services and consumers. Experience with the first round of contracts reinforced the need for core services descriptions that were sufficiently differentiated to reflect the variety of programs or types of services within each category and yet were general enough to encompass the broad diversity of service modalities in Virginia. That experience also established the need for basic, quantified data about services, collected and reported uniformly.

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (Department) and the Virginia Association of Community Services Boards (VACSB) developed the first version of a core services taxonomy, a classification and definition of services, to address these needs. The original version was used for the FY 1986 and 1987 community services performance contracts. The State Board adopted Policy 1021 (SYS) 87-9 on core services in 1987. The policy states that the current version of the taxonomy will be used to classify, describe, and measure the services delivered by all community services boards (CSBs) and state facilities.

A revised core services taxonomy was produced for the FY 1988 and 1989 performance contracts. A third version was developed for FY 1990 and 1991, a fourth for FY 1992 and 1993, and a fifth for the FY 1994 and 1995 contracts. Core Services Taxonomy 6 was used for FY 1996 and subsequent years through FY 2005, during which it was updated eight times.

Core Services Taxonomy 7 adds one new core services category, Limited Services, separates Outpatient and Case Management Services into two categories to provide more visibility for Case Management Services, and splits Day Support Services into Day Support Services and Employment Services to reflect the clear differences between them. The Limited Services category allows CSBs to capture less information about services that are typically short-term (e.g., less than 30 days duration or four to eight sessions) or infrequent or low intensity services. As a result, Taxonomy 7 has nine categories of core services: Emergency, Inpatient, Outpatient, Case Management, Day Support, Employment, Residential, Prevention and Early Intervention, and Limited Services. Taxonomy 7 also includes 27 subcategories, different types of similar services within various core services categories. Core Services Taxonomy 7 will be effective on July 1, 2005 for FY 2006 and subsequent fiscal years.

The taxonomy categories and subcategories are intended to be inclusive rather than narrowly exclusive; they are not meant to capture every detail about everything a CSB or state facility does. The categories and subcategories are meant to allow meaningful and accurate descriptions and measurements of service delivery activities; this can help produce valid and informative analyses and comparisons of CSBs, state facilities, and regions.

Because of the diversity and variety that characterize Virginia's localities and the mix and availability of resources and services from other public and private providers, each CSB may not need to develop or provide services in every subcategory of the core services taxonomy. The list of categories and subcategories does not constitute additional mandates for CSBs; only emergency and case management services are now required. Similarly, each state facility will not need to develop or provide services in every subcategory of the inpatient core services category. Finally, this core services taxonomy, including the services definitions, subcategories, levels of service, performance contract definitions, and other elements, will continue to evolve in response to future changes in the organization and operation of state facilities and community services, as Virginia develops a more fully consumer-focused system of care that emphasizes recovery, self-determination, empowerment, and resilience for individuals with mental illnesses, mental retardation, or substance use disorders.

The following graphic portrays the relationship of the core services categories and subcategories in the taxonomy to the more traditional organizational structure of community services.

Community Services Board (CSB), Behavioral Health Authority (BHA), or Local Government Department with a Policy-Advisory CSB

PROGRAM AREA (all mental health, mental retardation, or substance abuse services)

Core Service Category (e.g., Residential Services)

Core Service Subcategory (e.g., Intensive Residential Services)

Individual Program (e.g., a particular group home)

Discrete Service Activity (e.g., meal preparation)

The numbers after some core services categories and all core service subcategories in the definitions section and the matrix are the Community Automated Reporting System (CARS) and Community Consumer Submission (CCS) codes for those services. For example, within the **Inpatient Services** category, ***Acute Psychiatric or Substance Abuse Inpatient Services*** are coded as (250). In CARS and CCS, core services categories with subcategories, such as **Inpatient Services**, do no have codes because they have subcategories with codes in service menus or lists. However, core services categories with no subcategories, such as **Emergency Services**, do have codes and are included on those menus or lists. Even though some services have moved to different categories, such as ***Individual Supported Employment*** moving from the **Day Support Services** to the **Employment Services** category or ***Substance Abuse Motivational Treatment Services*** moving from the **Outpatient Services** to the **Limited Services** category, all services retain the same code numbers that they had in Taxonomy 6 and the original CCS for historical data base continuity purposes, except for ***Substance Abuse Social Detoxification Services***, which will now be coded as 710 to avoid conflicts with the ***Highly Intensive Residential Services*** code (501).

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Types of Community Services Boards (CSBs)

A particularly meaningful classification of CSBs is the relationship between the CSB and its local government or governments. While CSBs are agents of the local governments that established them, most CSBs are not city or county government departments. Sections 37.1-194 and 194.1 of the *Code of Virginia* define three types of CSBs, and Chapter 15 of Title 37.1 authorizes behavioral health authorities (BHAs) to provide community services. Throughout this taxonomy, the term community services board and the CSB acronym will be used to refer to all of these organizations.

Administrative Policy CSB means the public body, organized in accordance with the provisions of Chapter 10 of Title 37.1 of the *Code of Virginia*, that is appointed by and accountable to the governing body of each city and county that established it to set policy for and administer the provision of mental health, mental retardation, and substance abuse services. Administrative Policy CSB denotes the board, the members of which are appointed pursuant to § 37.1-195 with the powers and duties enumerated in §§ 37.1-197 and -197.1 of the *Code of Virginia*. Administrative policy CSB also includes the organization that provides such services through local government staff or through contracts with other organizations and providers. Administrative Policy CSBs do not employ their own staff. There are 10 administrative policy CSBs; seven are city or county government departments; three are not, but they use local government staff to provide services.

Behavioral Health Authority (BHA) means a public body and a body corporate organized in accordance with the provisions of Chapter 15 of Title 37.1 that is appointed by and accountable to the governing body of the city or county that established it for the provision of mental health, mental retardation, and substance abuse services. BHA also includes the organization that provides such services through its own staff or through contracts with other organizations and providers, unless the specific context indicates otherwise. Chapter 15 authorizes Chesterfield, Richmond, and Virginia Beach to establish BHAs; a BHA now exists only in Richmond. In many ways, a BHA most closely resembles an operating CSB, but it has several powers or duties, listed in § 37.1-248 of the *Code of Virginia*, that are not given to CSBs.

Operating CSB means the public body, organized in accordance with the provisions of Chapter 10 of Title 37.1 of the *Code of Virginia*, that is appointed by and accountable to the governing body of each city and county that established it for the direct provision of mental health, mental retardation, and substance abuse services. The operating CSB denotes the board, the members of which are appointed pursuant to § 37.1-195 with the powers and duties enumerated in §§ 37.1-197 and -197.1 of the *Code of Virginia*. Operating CSB also includes the organization that provides such services, through its own staff or through contracts with other providers, unless the specific context indicates otherwise. The 28 operating CSBs employ their own staff and are not city or county government departments.

Policy-Advisory CSB means the public body, organized in accordance with the provisions of Chapter 10 of Title 37.1 of the *Code of Virginia*, that is appointed by and accountable to the governing body of each city and county that established it to provide advice on policy matters to the local government department that provides mental health, mental retardation, and substance abuse services directly or through contracts with other providers pursuant to §§ 37.1-197 and -197.1 of the *Code of Virginia*. Policy-Advisory CSB denotes the board, the members of which are appointed pursuant to § 37.1-195 with the powers and duties enumerated in § 37.1-197 of the *Code of Virginia*. The CSB has no operational powers or duties; it is an advisory board to a local government department. There is one local government department with a policy-advisory CSB, the Portsmouth Department of Behavioral Healthcare Services.

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Core Services Definitions: Categories and Subcategories of Services

1. **Emergency Services** (100) are unscheduled and sometimes scheduled crisis intervention, stabilization, and referral assistance provided over the telephone or face-to-face, if indicated, 24 hours per day and seven days per week, to people seeking such services for themselves or others. Services also may include walk-ins, home visits, and jail interventions. Emergency Services include preadmission screening or other activities that prevent admission to a mental health hospital or mental retardation training center or are associated with the judicial admission process.

   This category also includes Medicaid Crisis Intervention and Short-Term Crisis Counseling and Mental Retardation Home and Community-Based (MRHCB) Waiver Crisis Stabilization and Personal Emergency Response System Services.

2. **Inpatient Services** deliver services on a 24-hour-per-day basis in a hospital or training center setting.

   a. ***Medical/Surgical Care*** provides acute medical treatment or surgical services in state facilities. Such services include medical detoxification, orthopedics, oral surgery, urology, care for pneumonia, post-operative care, ophthalmology, ear, nose and throat care, and other intensive medical services.

   b. ***Skilled Nursing Services*** deliver medical care, nursing services, and other ancillary care for people with mental disabilities who are in state facilities and require nursing as well as other care. Skilled nursing services are most often required by persons who are acutely ill or have severe or profound mental retardation and by elderly adults with mental illness who suffer from chronic physical illnesses and loss of mobility. These services are provided by professional nurses, licensed practical nurses, and qualified paramedical personnel under the general direction and supervision of a physician.

   c. ***Intermediate Care Facility/Mentally Retarded (ICF/MR) Services*** are provided in state training centers for people with mental retardation who require active habilitative and training services, including respite and emergency care, but not the degree of care and treatment provided in a hospital or skilled nursing home.

   d. ***Intermediate Care Facility/Geriatric Services*** are provided in state geriatric facilities by interdisciplinary teams to patients who are 65 years of age and older. Services include psychiatric treatment, medical treatment, personal care, and therapeutic programs appropriate to the facility and to the patient's needs.

   e. ***Acute Psychiatric or Substance Abuse Inpatient Services*** (250) provide intensive short-term psychiatric treatment in state hospitals or intensive short-term psychiatric treatment, including services to persons with mental retardation, or substance abuse treatment, except detoxification, in local hospitals. Services include intensive stabilization, evaluation, psychotropic medications, psychiatric and psychological services, and other supportive therapies provided in a highly structured and supervised setting.

   f. ***Community-Based Substance Abuse Medical Detoxification Inpatient Services*** (260) use medication under the supervision of medical personnel in local hospitals or other 24 hour per day care facilities to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

g. ***Extended Rehabilitation Services*** offer intermediate or long-term treatment in a state hospital for individuals with severe psychiatric impairments, emotional disturbances, or multiple handicaps (e.g., people with mental illnesses who also are deaf). Services include rehabilitation training, skills building, and behavioral management for people who are beyond the crisis stabilization and acute treatment stages.

3. **Outpatient Services** provide clinical treatment services, generally in sessions of less than three consecutive hours, to individuals and groups. *Italicized services* not in bold type described in some of the following subcategories are included only for illustrative purposes.

a. ***Outpatient Services*** (310) are generally provided to consumers on an hourly schedule, on an individual, group, or family basis, and usually in a clinic or similar facility or in another location. Outpatient Services may include diagnosis and evaluation, screening and intake, counseling, psychotherapy, behavior management, psychological testing and assessment, laboratory and other ancillary services, medical services, and medication services. Medical services include the provision of psychiatric, medical, psychiatric nursing, and medical nursing services by licensed psychiatrists, physicians, and nurses and the cost of medications purchased by the CSB and provided to consumers. Medication services include prescribing and dispensing medications, medication management, and pharmacy services. Medication only visits include only consumers who receive only medication monitoring on a periodic (monthly or quarterly) basis from a psychiatrist, other MD, psychiatric nurse, or physician's assistant. These visits are included in Outpatient Services. The Department has identified a minimum set of information for licensing purposes that would be needed to constitute an individualized services plan (ISP) for medication only consumers.

Outpatient Services also include *Intensive Substance Abuse Outpatient Services* that are provided generally in a concentrated manner over a four to 12 week period for consumers who require intensive outpatient stabilization, such as people with severe psychoactive substance use disorders. Usually, intensive outpatient services include multiple group therapy sessions during the week plus individual and family therapy, consumer monitoring, and case management.

Outpatient Services also include *Intensive In-home Services* that are time-limited, usually between two and six months, family preservation interventions for children and adolescents with or at risk of serious emotional disturbance, including such individuals who also have a diagnosis of mental retardation. In-home services are provided typically but not solely in the residence of an individual who is at risk of being moved into or who is being transitioned to home from an out-of-home placement. These services provide crisis treatment; individual and family counseling; life, parenting, and communication skills; case management activities and coordination with other required services; and 24 hour per day emergency response.

Finally, Outpatient Services also include Medicaid MRHCB Waiver Skilled Nursing Services and Therapeutic Consultation Services. Probation and Parole and Community Corrections Day Reporting Centers also are included in Outpatient Services, rather than in Limited Services.

b. **Opioid Detoxification Services** (330) combine outpatient treatment with administering or dispensing synthetic narcotics, such as methadone, approved by the federal Food and Drug Administration as a substitute for opioid substances, such as heroin or other narcotic drugs, in decreasing doses to reach a drug-free state in a period not to exceed 180 days.

c. ***Opioid Treatment Services*** (340) combine outpatient treatment with administering or dispensing synthetic narcotics, such as methadone, approved by the federal Food and Drug Administration for the purpose of replacing the use of and reducing the craving for opioid substances, such as heroin or other narcotic drugs.

d. ***Assertive Community Treatment*** (350) includes two modalities, Intensive Community Treatment (ICT) and Programs of Assertive Community Treatment (PACT). Individuals served by either modality have severe symptoms and impairments that are not effectively remedied by available treatments or, because of reasons related to their mental illnesses, resist or avoid involvement with mental health services. This could include individuals with severe and persistent mental illnesses who also have co-occurring diagnoses of mental retardation. Assertive Community Treatment provides an array of services on a 24-hour per day basis to these individuals in their natural environments to help them achieve and maintain effective levels of functioning and participation in their communities. Services may include case management; supportive counseling; symptom management; medication administration and compliance monitoring; crisis intervention; developing individualized community supports; psychiatric assessment and other services; and teaching daily living, life, social, and communication skills.

Intensive Community Treatment is provided by a self-contained, interdisciplinary team of at least five full-time equivalent clinical staff, a program assistant, and a psychiatrist that (1) assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses; (2) minimally refers individuals to outside service providers; (3) provides services on a long-term care basis with continuity of caregivers over time; (4) delivers 75 percent or more of the services outside of the program's offices; and (5) emphasizes outreach, relationship building, and individualization of services.

Program of Assertive Community Treatment is provided by a self-contained, inter-disciplinary team of at least 10 full-time equivalent clinical staff, a program assistant, and a psychiatrist that meets the five criteria contained in the definition of *Intensive Community Treatment*.

4. **Case Management Services** (320) assist individuals and their family members to access needed services that are responsive to the person's individual needs. Services include: identifying and reaching out to potential consumers; assessing needs and planning services; linking the individual to services and supports; assisting the person directly to locate, develop or obtain needed services and resources; coordinating services with other providers; enhancing community integration; making collateral contacts; monitoring service delivery; and advocating for people in response to their changing needs.

5. **Day Support Services** provide structured programs of treatment, activity, or training services, generally in clusters of two or more continuous hours per day, to groups or individuals in non-residential settings. *Italicized services* not in bold type described in the following subcategories are included only for illustrative purposes.

a. ***Day Treatment/Partial Hospitalization*** (410) is a treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational and educational treatment modalities designed for adults with serious mental illnesses or substance use disorders who require coordinated, intensive, comprehensive, and multi-disciplinary treatment of pathological conditions that is not provided in outpatient services.

This subcategory also includes *Therapeutic Day Treatment for Children and Adolescents*, a treatment program that serves children and adolescents (birth through age 17) with serious emotional disturbances or children (birth through age 7) at risk of serious emotional disturbance in order to combine psychotherapeutic interventions with education and mental health treatment. Services include: evaluation, medication education and management, opportunities to learn and use daily living skills and to enhance social and interpersonal skills, and individual, group, and family counseling.

b. ***Rehabilitation/Habilitation*** (425) includes training opportunities in two modalities.

Psychosocial Rehabilitation provides assessment, medication education, opportunities to learn and use independent living skills and to enhance social and interpersonal skills, family support and education, vocational and educational opportunities, and advocacy in a supportive community environment focusing on normalization. It emphasizes strengthening the person's abilities to deal with everyday life rather than focusing on treating pathological conditions.

Habilitation provides planned combinations of individualized activities, supports, training, supervision, and transportation to individuals with mental retardation to improve their condition or maintain an optimal level of functioning. Specific components of this service develop or enhance the following skills: self-care and hygiene, eating, toileting, task learning, community resource utilization, environmental and behavioral skills, medication management, and transportation.

Rehabilitation/Habilitation also includes *Alternative Day Support Arrangements* that assist people to locate day support settings and may provide program staff, follow along, or assistance to these individuals with a focus on assisting the person to maintain an independent day support arrangement and *Education/Recreation Services* that provide education, recreation, enrichment, and leisure activities daily, weekly, or monthly, during the summer or throughout the year. Habilitation also includes Medicaid MRHCB Waiver Day Support (Center-Based and Non-Center- Based) and Prevocational Services.

6. **Employment Services** provide work and support services to groups or individuals in non-residential settings.

a. ***Sheltered Employment*** (430) programs provide work in a non-integrated setting that is compensated in accordance with the Fair Labor Standards Act for individuals with disabilities who are not ready, are unable, or choose not to enter into competitive employment in an integrated setting. This service includes the development of social, personal, and work-related skills based on an individualized consumer service plan.

b. ***Group Supported Employment*** (465) provides work to small groups of three to eight individuals at job sites in the community or at dispersed sites within an integrated setting. Integrated setting means opportunities exist for consumers in the immediate work setting to have regular contact with non-disabled individuals who are not providing support services. The employer or the vendor of supported employment services employs the consumers. An employment specialist, who may be employed by the employer or the vendor, provides ongoing support services. Support services are provided in accordance with the consumer's individual written rehabilitation plan. Models include mobile and stationary crews, enclaves, and small businesses. Group Supported Employment includes Medicaid MRHCB Waiver Supported Employment - Group Model.

c. ***Individual Supported Employment*** (460) provides paid employment to a consumer placed in an integrated work setting in the community. The employer employs the consumer. On-going support services that may include transportation, job-site training, counseling, advocacy, and any other supports needed to achieve and to maintain the consumer in the supported placement are provided by an employment specialist, co-workers of the supported employee, or other qualified individuals. Support services are provided in accordance with the consumer's individual written rehabilitation plan.

Individual Supported Employment also includes *Transitional Employment* services that involve a sequence of temporary supported placements that result in a final competitive employment placement with or without supports. Service units may be included here or as part of another program, such as psychosocial rehabilitation, depending on how the service is delivered and its relative volume. Individual Supported Employment includes Medicaid MR HCB Waiver Supported Employment - Individual Model.

7. **Residential Services** provide overnight care with an intensive treatment or training program in a setting other than a hospital or training center, overnight care with supervised living, or other supportive residential services. Information about numbers of consumers served, units of services, and expenses are projected and reported only at the subcategory level. *Italicized services* not in bold type described in the following subcategories are included only for illustrative purposes.

a. ***Highly Intensive Residential Services*** (501) provide **overnight care with intensive treatment or training services**. These services include: mental health residential treatment centers such as short term intermediate care, crisis stabilization, residential alternatives to hospitalization, and residential services for individuals with co-occurring diagnoses (e.g., mental illness and substance use disorder, mental retardation and mental illness) where intensive treatment rather than just supervision occurs and Intermediate Care Facilities for Mentally Retarded persons (ICF/MR) that deliver active habilitative and training services in a community setting. This subcategory also includes *Community Gero-psychiatric Residential Services* that provide 24-hour non-acute care with treatment in a setting that offers less intensive services than a hospital, but more intensive mental health services than a nursing home or group home. Individuals with mental illness, behavioral problems, and concomitant health problems, usually age 65 and older, who are appropriately treated in a geriatric setting, receive intense supervision, psychiatric care, behavioral treatment planning, nursing, and other health-related services.

b. ***Intensive Residential Services*** (521) provide **overnight care with treatment or training that is less intense than highly intensive residential services**. It includes the following services and Medicaid MRHCB Waiver Congregate Residential Support Services.

Primary Care offers substance abuse rehabilitation services that normally last no more than 30 days. Services include intensive stabilization, daily group therapy and psycho-education, consumer monitoring, case management, individual and family therapy, and discharge planning.

Intermediate Rehabilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay up to 90 days. Services include supportive group therapy, psycho-education, consumer monitoring, case management, individual and family therapy, employment services, and community preparation services.

Long-Term Habilitation is a substance abuse psychosocial therapeutic milieu with an expected length of stay of 90 or more days that provides a highly structured environment where residents, under staff supervision, are responsible for daily operations of the facility. Services include intensive daily group and individual therapy, family counseling, and psycho-education. Daily living skills and employment opportunities are integral components of the treatment program.

Group Homes or Halfway Houses are facilities that provide identified beds and 24 hour supervision for individuals who require training and assistance in basic daily living functions such as meal preparation, personal hygiene, transportation, recreation, laundry, and budgeting. The expected length of stay normally exceeds 30 days.

c. ***Jail-Based Habilitation Services*** (531) offer a substance abuse psychosocial therapeutic community with an expected length of stay of 90 days or more that provides a highly structured environment where residents, under staff and correctional supervision, are responsible for the daily operations of the program. Services include intensive daily group counseling, individual therapy, psycho-educational services, 12 step meetings, discharge planning, and pre-employment and community preparation services. Daily living skills in conjunction with the therapeutic milieu structure are an integral component of the treatment program. Normally, inmates served by this program are housed separately within the jail.

d. ***Supervised Residential Services*** (551) offer **overnight care with supervision and services**. This subcategory includes the following services and Medicaid MRHCB Waiver Congregate Residential Support Services.

Supervised Apartments are directly-operated or contracted, licensed or unlicensed, residential programs that place and provide services to individuals in apartments or other residential settings. The expected length of stay normally exceeds 30 days.

Domiciliary Care provides food, shelter, and assistance in routine daily living but not treatment or training in facilities of five or more beds. This is primarily a long-term setting with an expected length of stay exceeding 30 days. Domiciliary care is less intensive than a group home or supervised apartment; an example would be a licensed assisted living facility (ALF) operated, funded, or contracted by a CSB.

Emergency Shelter or Residential Respite programs provide identified beds, supported or controlled by a CSB, in a variety of settings reserved for short term stays, usually several days to no more than 21 consecutive days.

Sponsored Placements place people in residential settings and provide substantial amounts of financial, programmatic, or service support. Examples include individualized therapeutic homes, specialized foster care, family sponsor homes, and residential services contracts for specified individuals. The focus is on individual consumer residential placements with expected lengths of stay exceeding 30 days rather than on organizations with structured staff support and set numbers of beds.

d. ***Supportive Residential Services*** (581) are unstructured services that support individuals in their own housing arrangements. These services normally do not involve overnight care delivered by a program. However, due to the flexible nature of these services, overnight care may be provided on an hourly basis. It includes the following services and Medicaid MRHCB Waiver Supported Living/In-Home Supports, Respite (Agency and Consumer-Directed) Services, Companion Services (Agency and Consumer-Directed), and Personal Assistance Services (Agency and Consumer-Directed).

In-Home Respite provides care in the homes of people with mental disabilities or in a setting other than that described in residential respite services above. This care may last from several hours to several days and allows the family member care giver to be absent from the home.

Supported Living Arrangements are residential alternatives that are not included in other types of residential services. These alternatives assist people to locate or maintain residential settings where access to beds is not controlled by a CSB and may provide program staff, follow along, or assistance to these individuals. The focus may be on assisting an individual to maintain an independent residential arrangement. Examples include homemaker services, public-private partnerships, and non-CSB subsidized apartments (e.g., HUD certificates).

Housing Subsidies provide cash payments only, with no services or staff support, to enable consumers to live in housing that would otherwise not be accessible to them. These cash subsidies may be used for rent, utility payments, deposits, furniture, and other similar payments required to initiate or maintain housing arrangements for consumers. This is used only for specific allocations of funds from the Department that are earmarked for housing subsidies. Numbers of consumers and expense information should be included in supportive residential services in the contract and reports. Information associated with other housing subsidies should be included in the services of which they are a part.

8. **Prevention and Early Intervention Services** are designed to prevent or intervene early in the process of mental illness, mental retardation, or substance use disorder, including enhancing the development of handicapped or at-risk infants and toddlers. Activities should not be included in prevention or early intervention services that are really outpatient services to avoid record keeping or licensing requirements, since this exposes the CSB to increased liability and is not clinically appropriate. School-Based Interventions should be included in Prevention, Early Intervention, or Outpatient Services, as appropriate.

   a. ***Prevention Services*** (610) involve people, families, communities, and systems working together to promote their strengths and potentials. Prevention is aimed at substantially reducing the incidence of mental illness, mental retardation and other developmental disabilities, and substance use disorders. Emphasis is on enhancement of protective factors and reduction of risk factors. The following six activities comprise prevention services. Information about these activities will be collected and reported separately from the performance contract. Only units of services and expenses at the prevention services level and amounts of funds expended for each of these six activities will be projected and reported through the performance contract process.

   Information Dissemination provides awareness and knowledge of the nature and extent of mental illness, mental retardation, developmental disabilities, and substance use disorders. It also provides awareness and knowledge of available prevention programs and services. Examples of information dissemination include media campaigns, public service announcements, informational brochures and materials, community awareness events, and participation on radio or TV talk shows. Information dissemination is characterized by one-way communication from the source to the audience.

   Prevention Education aims to affect critical life and social skills, including general competency building, specific coping skills training, support system interventions, strengthening caregivers, and decision-making skills training. Prevention education is

characterized by two-way communication with close interaction between the facilitator or educator and the program participants. Examples of prevention education include children of alcoholics groups and parenting classes.

Alternatives provide for the participation of specific populations in activities that are constructive, promote healthy choices, and provide opportunities for skill building. Examples of prevention alternatives include leadership development; community service projects; alcohol, tobacco, and other drug free activities; and youth centers.

Problem Identification and Referral aims at the identification of those individuals who are most at risk of developing problematic behaviors in order to assess if their behaviors can be changed though prevention education. Examples include student and employee assistance programs.

Community-based Process aims at enhancing the ability of the community to provide prevention and treatment services more effectively. Activities include organizing, planning, enhancing efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Examples include community and volunteer training, multi-agency coordination and collaboration, accessing services and funding, and community team-building.

Environmental prevention activities establish or change written and unwritten community standards, codes, and attitudes, thereby influencing the development of healthy living conditions. Examples include modifying advertising practices and promoting the establishment and review of alcohol, tobacco, and other drug use policies.

Critical Incident Stress Debriefing (CISD) services are also a form of Prevention Services, but they are not included in the preceding activities. Individuals receiving CISD services will not be admitted to the CSB, enrolled in a service, or counted as consumers. Service units will be collected through the z-consumer function in the CCS.

b. ***Early Intervention Services*** (620) are intended to improve functioning or change behavior in those individuals identified as beginning to experience problems, symptoms, or behaviors that, without intervention, are likely to result in the need for treatment. Services are generally targeted to identified individuals or groups. Early Intervention Services include: case consultation, groups for adolescents who have been suspended for use of alcohol or tobacco, and programs for children or adults exhibiting behavior changes following loss such as divorce, death of a loved one, and job loss.

Early Intervention Services include *Infant and Toddler Intervention*, which provides family-centered, community-based early intervention services designed to meet the developmental needs of infants and toddlers and the needs of their families as these needs relate to enhancing the child's development. These services prevent or reduce the potential for developmental delays and increase the capacity of families to meet the needs of their at-risk infants and toddlers. Infant and toddler intervention is delivered through a comprehensive, coordinated, interagency, and multi-disciplinary services system. It may include audiology, family training, counseling and home visits, health, medical, nursing, nutrition, occupational therapy, physical therapy, special instruction, psychological, speech-language pathology, vision, and transportation services. The identified consumer is the infant or toddler.

9. **Limited Services** include the following activities that typically are short term, that is less than 30 days or four to eight sessions in duration, or infrequent or low-intensity services and do not require collection of as many data elements through the CCS or as much consumer service record information as other core services. However, all of the CCS data elements that were not collected when a consumer was enrolled in a Limited Service must be collected if that consumer is released from the Limited Service and enrolled subsequently in another core service, except for Emergency Services, during the same episode of care.

   a. ***Substance Abuse Social Detoxification Services*** (710) are provide in specialized non-medical facilities with physician services available when required that systematically reduce or eliminate the effects of alcohol or other drugs in the body, return a person to a drug-free state, and normally last up to seven days.

   b. ***Substance Abuse Motivational Treatment Services*** (318) are generally provided to consumers on an hourly basis, once per week, through individual or group counseling in a clinic. These services are structured to help consumers resolve their ambivalence about changing problematic behaviors by using a repertoire of data-gathering and feedback techniques. Motivational Treatment Services are not a part of another service; they stand alone. Their singular focus on increasing the consumer's motivation to change problematic behaviors, rather than on changing the behavior itself, distinguishes Motivational Treatment Services from Outpatient Services. A course of motivational treatment may involve a single session, but more typically four or eight sessions; and it may be repeated, if necessary, as long as repetition is clinically indicated. Prior to placement in motivational treatment, the consumer's level of readiness for change is usually assessed, based on clinical judgment, typically supported by standardized instruments. Such an assessment may also follow a course of motivational treatment to ascertain any changes in the consumer's readiness for change.

   c. ***Consumer Monitoring Services*** (390) are provided to consumers who have been admitted to a CSB but will not be receiving any other services immediately. This includes individuals who have been admitted to a CSB and assigned case managers but have not been enrolled in other services; instead, they have been placed on waiting lists for other services. These individuals receive no interventions or face-to-face contact in more than 180 days, but they receive Consumer Monitoring Services, which typically consist of service coordination or intermittent emergency contacts, at least once every 360 days. This also includes individuals who receive only outreach services, such as outreach contacts through Projects for Assistance in Transition from Homelessness (PATH). These individuals would be admitted to the CSB and enrolled in Consumer Monitoring Services. Finally, a consumer who is receiving only family support would be enrolled in Consumer Monitoring Services.

   d. ***Assessment and Evaluation Services*** (720) include court-ordered or psychological evaluations; initial assessments for screening, triage, and referral for individuals who probably will not continue in services; and initial evaluations or assessments that result in placement on waiting lists without receiving other services. An abbreviated individualized services plan and consumer record may be required.

Additional Community Consumer Submission (CCS) 900 Codes

The component services of certain initiatives are included in the appropriate core services (e.g., Outpatient, Case Management, and various Day Support and Residential Services) and numbers of consumers in these initiatives are counted in the CCS in the following manner. When a consumer is served in any of the following initiatives, the service code for the initiative will be entered in the consumer's enrollment record.

910 - Discharge Assistance Project (DAP)
915 - Non-CSA Mandated Mental Health Child and Adolescent Services,
918 - Program of Assertive Community Treatment (PACT),
919 - Projects for Assistance in Transition from Homelessness (PATH)
920 - Medicaid Mental Retardation Home and Community-Based Waiver Services, and
930 - Substance Abuse State Facility Admission Diversion Project.

Units of service for these initiatives will be recorded and accumulated in the applicable core services associated with the initiative, such as Outpatient, Case Management, Day Treatment/Partial Hospitalization, Rehabilitation/Habilitation, or various Residential Services.

Service code 920 is used only for consumers receiving Medicaid MR Waiver Services from a CSB, directly or through CSB contracts with other agencies or individuals where the CSB remains the provider for Department of Medical Assistance (DMAS) purposes. Service code 920 is not used for a consumer who is enrolled in the MR Waiver, but is receiving Waiver services from another provider that is reimbursed directly by the DMAS, and is receiving only targeted case management, which is not a Waiver service, from the CSB.

Additional CCS 900 codes also may be used to identify consumers involved in special projects and to gather information about those consumers and the services associated with those projects through the special project report function of the Community Consumer Submission 2. The Department, in conjunction with the VACSB Data Management Committee, will designate and approve additional 900 codes for such purposes.

Core Services Taxonomy Work Group Commentary

The following comments reflect the deliberations and decisions of the Core Services Taxonomy Work Group, which developed Taxonomy 7. These comments are included for information purposes.

Family Support offers assistance for families who choose to provide care at home for family members with mental disabilities. Family support is a combination of financial assistance, services, and technical supports that allows families to have control over their lives and the lives of their family members. Family is defined as the natural, adoptive, or foster care family with whom the person with a mental disability resides. Family can also mean an adult relative (i.e., sister, brother, son, daughter, aunt, uncle, cousin, or grand-parent) or interested person who has been appointed full or limited guardian and with whom the person with the mental disability resides. The family defines the support. While it will be different for each family, the support should be flexible and individualized to meet the unique needs of the family and the person with the mental disability. Family support services include respite care, adaptive equipment, personal care supplies and equipment, behavior management, minor home adaptation or modification, day care, and other extraordinary needs.

The identified consumer is the family member with a mental disability. Family support is a revenue source that funds activities in various services, such as Case Management, Rehabilitation, and Supervised or Supportive Residential Services, rather than a separate core service subcategory.

The revenue and expenses for family support activities would be included in the applicable core service subcategories, but numbers of consumers would not be included separately, since those individuals are already receiving the service in the subcategory (e.g., Case Management, Rehabilitation, and Supervised or Supportive Residential Services). **If a consumer is receiving nothing but family support, he or she should be enrolled in Consumer Monitoring, since all consumers must be enrolled in a service**. Family support also includes Medicaid MRHCB Waiver Environmental Modifications and Assistive Technology Services.

Consultations include Professional and Clinical Consultations with FAPTs (CSA), other human services agencies (e.g., associated with Title IV-E reimbursable services), and private providers. No ISPs are developed, and Department licensure is not required. In consultations, CSB staff members are not providing services to consumers or care coordination; the staff are only consulting with service providers and other agencies about individuals who are consumers of other organizations. Since there are no consumers counted for consultations, service units will be collected through the z-consumer function in the CCS. Traditionally, consultations have been included in Outpatient or Case Management Services and they will continue to be included in those services. However, if a CSB is providing other services, this is not a consultation situation; the consumer is admitted to the CSB and enrolled in the applicable service(s). For example, if a CSB is providing significant amounts of staff support associated with FAPT or Title IV-E activities, it may include this support as part of *Consumer Monitoring Services* under Limited Services.

Core Services Taxonomy 7

Core Services Category and Subcategory Matrix

Services	MH	MR	SA	Unit of Service	Static Capacity
1. **Emergency Services** (100)	x	x	x	Service Hour [a]	FTE
2. **Inpatient Services**					
a. Medical/Surgical Care (State Facility)	x	x		Bed Day	Bed
b. Skilled Nursing Services (State Facility)	x	x		Bed Day	Bed
c. ICF/MR Services (State Facility)		x		Bed Day	Bed
d. ICF/Geriatric Services (State Facility)	x	x		Bed Day	Bed
e. Acute Psychiatric or Substance Abuse Inpatient Services (250)	x		x	Bed Day	Bed
f. Community-Based Substance Abuse Medical Detoxification Inpatient Services (260)			x	Bed Day	Bed
g. Extended Rehabilitation Services (St. Facility)	x			Bed Day	Bed
3. **Outpatient Services**					
a. Outpatient Services (310)	x	x	x	Service Hour [a]	FTE
b. Opioid Detoxification Services (330)			x	Service Hour [a]	FTE
c. Opioid Treatment Services (340)			x	Service Hour [a]	FTE
d. Assertive Community Treatment (350)	x			Provider Service Hour	FTE
4. **Case Management Services** (320)	x	x	x	Provider Service Hour	FTE
5. **Day Support Services**					
a. Day Treatment/Partial Hospitalization (410)	x		x	Day Support Hour	Slot
b. Rehabilitation/Habilitation (425)	x	x	x	Day Support Hour	Slot
6. **Employment Services**					
a. Sheltered Employment (430)	x	x	x	Day of Service	Slot
b. Group Supported Employment (465)	x	x	x	Day of Service	Slot
c. Individual Supported Employment (460)	x	x	x	Provider Service Hour	FTE
7. **Residential Services**					
a. Highly Intensive Residential Services (501)	x	x		Bed Day	Bed
b. Intensive Residential Services (521)	x	x	x	Bed Day	Bed
c. Jail-Based Habilitation Services (531)			x	Bed Day	Bed
d. Supervised Residential Services (551)	x	x	x	Bed Day	Bed
e. Supportive Residential Services (581)	x	x	x	Provider Service Hour	FTE
8. **Prevention and Early Intervention Services**					
a. Prevention Services (610)	x	x	x	Provider Service Hour	FTE
b. Early Intervention Services (620)	x	x	x	Provider Service Hour	FTE
9. **Limited Services**					
a. SA Social Detoxification Services (710)			x	Bed Day	Bed
b. SA Motivational Treatment Services (318)			x	Service Hour [a]	FTE
c. Consumer Monitoring Services (390)	x	x	x	Service Hour [a]	FTE
d. Assessment and Evaluation Services (720)	x	x	x	Provider Service Hour	FTE

Service hour [a] for these services (Emergency, Outpatient, Opioid Detoxification, Opioid Treatment, SA Motivational Treatment, and Consumer Monitoring Services) includes provider service hour, projected in the performance contract, and provider service hour and consumer service hour, each reported separately in the Community Consumer Submission and in Performance Contract Reports.

Core Services Taxonomy 7

Core Services Definitions: Levels of Services

There are two levels of services in this core services taxonomy: contract and actual. The ***contract level*** of services is the number of units of service that the CSB expects to deliver during the contract period. Contract levels are projected in the community services performance contract for all core services categories and subcategories. The ***actual level*** of services is the number of units of service actually delivered during the contract period. Actual levels are reported for all core services categories and subcategories in performance contract reports and in the Community Consumer Submission (CCS).

Core Services Definitions: Units of Service

There are four kinds of service units in this core services taxonomy: service hours, bed days, day support hours, and days of service. These units are related to different kinds of core services and are used to measure, project, and report delivery of those services.

1. ***Service Hours***

   A service hour is a continuous period measured in fractions or multiples of an hour during which a consumer or group participates in or benefits from the receipt of services. There are two types of service hours: provider service hours and consumer service hours. Provider service hours are projected in performance contracts, shown in performance contract reports, and collected though the CCS for all services for which the static capacity is an FTE. Consumer service hours are not projected in performance contracts but are shown in contract reports and collected though the CCS for the following core services: Emergency, Outpatient, Opioid Detoxification, Opioid Treatment, Substance Abuse Motivational Treatment, and Consumer Monitoring Services.

   a. **Provider service hours** measure the amount of staff effort related to the provision of services and are used to calculate unit costs. Provider service hours are hours that are available from all staff providing **direct and consumer-related services** to consumers. For staff with multiple responsibilities, such as program managers who provide some consumer services, include only the portion of time actually available for those services. For example, if a mental health director serves consumers during 20 percent of the work week, that time should be included in provider service hour calculations.

      Since the unit of service is an hour, fractional units should be rounded upward to the nearest quarter hour and quarter hours should be aggregated to whole hours. Unit costs should be calculated based on the sum of the direct and consumer-related provider service hours in the performance contract or in contract reports and the CCS. For some services, such as outpatient services, a direct service unit cost may be calculated using only the direct provider service hours.

   The following discussion is included only for information purposes, since only total service hours (direct and consumer-related) are projected or reported for provider service hours. Service hours are calculated based on the following table. CSBs may calculate consumer-related service hours for performance contract purposes (to accurately project the total provider service hours) based on historical patterns of actual service delivery or by using subcategory-specific formulas developed by the Department and the Virginia Association of Community Services Boards (VACSB). Indirect services are included in the table only for use in calculating the contract level of provider service hours.

   There are three classifications of activities and services for provider service hours: direct services, consumer-related services, and indirect services. The VACSB Administration

Committee and the Department developed the descriptions and the table below. While not all inclusive, they represent the most common activities and services.

Direct Services are activities that occur with the consumer or consumer group present, face-to-face or directly involved. For Prevention Services only, this includes services provided to individuals, families, groups, and agencies.

Consumer-Related Services are services that can be directly attributed to a specific consumer or consumer group, including report writing associated with direct services such as evaluation of a consumer. For Prevention Services only, this includes activities such as planning and preparation associated with direct services to individuals, families, groups, or agencies.

Indirect Services are activities of a general nature that are not attributable to a specific consumer or named consumer group. These services normally relate to the administrative activities of the organization.

Direct Services	
Individual, Group, Family, Marital, and Rape Counseling and Therapy	Activity or Recreation Therapy
	Skill-Building Group Training
Psychological Testing	Follow Up and Outreach
Medication Visit, Physician Visit	Phone Consultation with Consumer
Social Security Disability Evaluation	Employee, Student, and Peer Assistance
Intake, Psychiatric, Forensic, Court, and Jail Evaluations	Peer Self Help or Support
	Neighborhood-Based High Risk Youth Programs
Crisis Intervention	Children of Alcoholics Programs
Preadmission Screening	Competency Building Programs
Discharge Planning, Consumer Present	Early Intervention Activities
Emergency Telephone Contacts	Infant and Toddler Intervention Activities
Attending Court with Consumer	Healthy Pregnancies and Fetal Alcohol Syndrome Education
Case Management, Consumer Present	
Individual or Group Consumer Training	Shaken Baby, Child Abuse and Neglect Prevention and Positive Parenting Programs
Consumer Education	
Consumer-Related Services	
Case-specific Clinical Supervision	Discharge Planning, Consumer not Present
Consumer Record Charting	Case Management, Consumer not Present
Case Consultation	Coordination of Multi-disciplinary Teams
Treatment Planning Conference	Consultation to Service Providers
Report Writing Re: Consumer	Prevention and Early Intervention Planning and Preparation
Consumer-Related Staff Travel	
Application for Admission to Facility	Preparing Educational Materials for Prevention and Early Intervention Programs
Job Development for Consumers	
Staff Preparation for Individual, Group, and Family Counseling or Therapy	Preparing for Conferences, Workshops, Training
	Staff support to SODA programs
Indirect Services	
Facility or Vehicle Maintenance	General Staff Travel
Administrative Supervision	Staff and Volunteer Training
Committee Participation	Administrative Meetings
Unreported Time	

b. **Consumer service hours** measure the amounts of face-to-face services received by individual consumers. Usually, provider and consumer service hours will be the same or almost so, except in situations where a provider delivers services to more than one consumer at the same time. For example, if a consumer participates in one hour of individual therapy, the units of service would be one provider service hour and one consumer service hour. However, if the consumer participates in one hour of group therapy with eight other consumers, the units of service would be one provider service hour and nine consumer service hours. Consumer service hours are not projected in performance contracts but are reported in performance contract reports and the CCS for services where there could be a significant difference between the numbers of provider and consumer service hours: Emergency, Outpatient, Opioid Detoxification, Opioid Treatment, Motivational Treatment, and Consumer Monitoring Services. Consumer service hours also could include applicable consumer-related services. Consumer service hours also can be reported for other services for which the unit is a service hour, except for Prevention Services, since consumers are not identified for Prevention.

2. ***Bed Days***

A bed day involves an overnight stay by a consumer in a residential or inpatient program, facility, or service. Given the unique character of social detoxification, CSBs may count partial bed days for this service. If a consumer is in a social detoxification program for up to six hours, this would equal ¼ bed day, six to 12 hours would equal ½ bed day, 12 to 18 hours would equal ¾ bed day, and 18 to 24 hours would equal one bed day.

3. ***Day Support Hours***

Many day support services provided to groups of individuals are offered in sessions of two or more consecutive hours. However, Medicaid billing units for State Plan Option and MR Waiver services vary by service. Therefore, counting service units by the smallest reasonable unit, a day support hour, is desirable and useful. Medicaid service units, if different from Taxonomy units of service, need to be converted to Taxonomy units if Medicaid services are included in performance contracts and reports and the CCS. The day support hour is the unit of service for Day Treatment/Partial Hospitalization and Rehabilitation/Habilitation. It measures hours received by consumers in those services.

A day support hour is different from a provider and consumer service hours, which are used to report Outpatient Services delivered to consumers. Provider service hour units include direct and consumer related activities. These distinctions do not exist for day support hours. This unit allows the collection of more accurate information about services and will facilitate billing various payors that measure service units differently. At a minimum, day support programs that deliver services on a group basis must provide at least two consecutive hours in a session to be considered a day support program.

4. ***Days of Service***

Two employment services provided to groups of individuals are offered in sessions of three or more consecutive hours. Thus, day of service is the unit of service for Sheltered Employment and Group Supported Employment. A day of service equals five or more hours of service received by a consumer. If a session lasts three or more but less than five hours, it should be counted as a half day. Since the unit of service is a day, fractional units should be aggregated to whole days in performance contracts and reports. Also, Medicaid service units, if different from Taxonomy units of service, need to be converted to Taxonomy units if Medicaid services are included in performance contracts and reports.

Core Services Definitions: Static Capacities

1. ***Full-Time Equivalent (FTE)***

   Full-time equivalent is the numeric representation of the total number of hours a staff position is available during the work year. For example, a position that is staffed full-time (e.g. 37.5 or 40 hours per week or 1,950 or 2,080 hours per year) equals one FTE. If a position is staffed at half of that number of hours or if a position is only filled for half of the work year, it equals ½ FTE (0.5 FTE).

2. ***Number of Beds***

   The number of beds is the total number of beds for which the facility or program is licensed and staffed or the number of beds contracted for during the performance contract period.

   If the CSB contracts for bed days without specifying a number of beds, convert the bed days to a static capacity by dividing the bed days by the days in the term of the CSB's contract (e.g., 365 for an annual contract, 183 for a new, half-year contract). If the CSB contracts for the placement of a specified number of individuals, convert this to the number of beds by multiplying the number of consumers by their average length of stay in the program and then dividing the result by the number of days in the CSB's contract period.

3. ***Number of Slots***

   Number of slots means the maximum number of distinct consumers who could be served during a day or a half-day session in most day support programs. It is the number of slots for which the program or service is staffed. For example, in psychosocial rehabilitation programs, the number of slots is not the total number of members in the whole program, it is the number of members who can be served at the same time during a session by the program.

   If the CSB contracts for days of service without specifying a number of slots, convert the days of service to a static capacity by dividing the days of service by the days in the term of the CSB's contract (e.g., 248 for an annual contract based on 365 days minus 105 weekend and 12 holiday days). If the CSB contracts for the placement of a specified number of individuals, convert this to days of service by multiplying the number of consumers by the average units of service they receive and then convert the resulting days of service to slots, per the preceding example.

   If the CSB contracts for day support hours without specifying a number of slots, convert the hours to a static capacity by dividing the day support hours by the number of hours the program is open daily and dividing the result by the number of days the program is open during the CSB's contract period.

Core Services Definitions: Consumers

Section 37.1-1 of the *Code of Virginia* defines a consumer as a current direct recipient of public or private mental health, mental retardation, or substance abuse treatment or habilitation services. For performance contract or report purposes, numbers of consumers will always be the total numbers of individuals who were projected in the performance contract to receive services or who are shown in performance contract reports as actually having received services during the contract period. The Community Consumer Submission (CCS) operationally defines consumers in terms of admission to and discharge from the CSB. Consumers are not counted in prevention programs. Other individuals seen in a program for whom separate consumer records are not opened could be counted and reported separately locally as other persons served, but counting and reporting other persons served is not possible in the performance contract and reports or the CCS.

State Facility Cost Accounting System Cost Centers and Codes

2. a. **Medical/Surgical** **410**
   1.) Acute Medical/Surgical (Certified) 411
   2.) Detoxification (Certified) 412

   b. **Skilled Nursing** **420**
   1.) Skilled Nursing-MR (Certified) 421
   2.) Special/Convalescent Care 422
   3.) Skilled Nursing-General (Certified) 423

   c. **Intermediate Care Facility/Mentally Retarded**
   1.) ICF/MR (Certified) - Summary **510**
   a.) Child Development Services 511
   b.) Educational Development Services 512
   c.) Multi-Handicapped Habilitation Services 513
   d.) Adult Training Services 514
   e.) Community Adjustment Services 515
   f.) Physical Habilitation Services 516
   g.) Social Skills Service 517
   h.) Maladaptive Behavior Services 518
   i.) Extended Care/Health Services 519
   j.) ICF/MR Certified (General) 529
   2.) ICF/MR (Non-Certified) - Summary **530**
   a.) Health Services - Emergency Care 531
   b.) ICF/MR Non-Certified (General) 539

   d. **Intermediate Care Facility/Geriatric** **440**
   1.) ICF (Certified) 441
   2.) Chronic Disease (Certified) 443

   e. **Acute Intensive Psychiatric** **455**
   1.) Acute Admissions Summary 456
   a.) Certified 457
   b.) Non-Certified 458
   2.) Intermediate Intensive Treatment 461
   3.) Geriatric Admissions 462
   4.) Substance Abuse 463

   g. **Extended Rehabilitation** **480**
   1.) Community Preparation/Psychosocial 481
   2.) Long Term Rehabilitation 482
   3.) Behavioral Development/Life Skills 483
   4.) Child and Adolescent Summary 484
   a.) Child Services 485
   b.) Adolescent Services 486
   c.) Child and Adolescent Services (General) 487
   5.) Clinical Evaluation 488
   6.) Forensic, Medium Security 490
   7.) Forensic, Maximum Security 491
   8.) Deaf 492
   9.) Forensic, Intermediate Security 493

Core Services Taxonomy 7

Performance Contract Definitions

Administrative and Management Expenses means the expenses incurred by the CSB for its administrative functions and for management support of services that it provides. Administrative expenses may include, but are not limited to, the following functions: overall leadership and supervision of the CSB organization (e.g., expenses for the Executive Director, Deputy Director or Director of Administration, and support staff), financial management, accounting, reimbursement, procurement, human resources management, information technology services, policy development, strategic planning, resource development and acquisition, quality improvement, risk management, facility and transportation management and maintenance, intergovernmental relations, Board member support, and media relations. Management expenses may include, but are not limited to: overall leadership and supervision of the CSB's programs and services (e.g., expenses for the clinical and support services directors and support staff) and management and supervision of individual programs and services. Administrative and management functions and expenses may be centralized or included in programs and services, depending on the CSB's organizational structure.

Admission means the process by which a CSB accepts a person for services. If a person is only interviewed regarding services or triaged and referred to another provider or system of care, that activity does not constitute an admission. The staff time involved in that activity should be recorded in the core service category or subcategory (e.g., Emergency or Outpatient Services) where the activity occurred as a z-consumer, a service with no associated consumer, for Community Consumer Submission (CCS) purposes. Admission is to the CSB, not to a specific program or service. All persons seen face-to-face for an assessment are admitted to a CSB and a clinical record is opened. Consumers who will be receiving services through a CSB-contracted program or service are admitted to the CSB, based upon a face-to-face clinical assessment. In order for a person to be admitted to a CSB, all of the following actions are necessary:

1. an initial contact is made,
2. a clinical screening or initial assessment is conducted,
3. a unique consumer identifier is assigned or retrieved from the management information system if the person has been admitted for a previous episode of care, and
4. the person is enrolled in a directly-operated or contractual service.

Admission to a CSB and the date of enrollment are the same for a consumer's first enrollment in a service. A consumer cannot be admitted to the CSB without being enrolled in a service, even if that is only Assessment and Evaluation, Consumer Monitoring, Substance Abuse Motivational Treatment, or Social Detoxification Services. For those Limited Services and for Emergency Services, the CCS requires collection of an abbreviated set of data elements, rather than a full set. However, all of the CCS data elements that were not collected then must be collected if a consumer is released from the Limited or Emergency Service and enrolled subsequently in another core service during the same episode of care. It is possible that an individual's admission to and discharge from a CSB, including enrollment and release from a core service, may occur on the same day, if there is only a single encounter.

Case Management CSB means the CSB that serves the area in which the consumer resides. The case management CSB is responsible for case management, liaison with the state facility when a person is admitted to a state facility, and discharge planning. Any change in case management CSB for a consumer shall be implemented in accordance with the current *Discharge Planning Protocols* to ensure a smooth transition for the consumer and the CSB. Case management CSB also means the CSB to which bed day utilization is assigned, beginning on the day of admission, for an episode of care and treatment when a consumer is admitted to a state facility.

Cognitive Delay means a child is at least three but less than six years old and has a confirmed cognitive developmental delay. Documentation of a confirmed cognitive developmental delay must be from a multidisciplinary team of trained personnel, using a variety of valid assessment instruments. A confirmed delay will be noted on the test with a score that is at least 25 percent below the child's chronological age in one or more areas of cognitive development. A developmental delay is defined as a significant delay in one of the following developmental areas: cognitive ability, motor skills, social/adaptive behavior, perceptual skills, or communication skills. A multidisciplinary team of trained personnel will measure developmental delay (25 percent below the child's chronological age) by a using a variety of valid assessment instruments. The most frequently used instruments in Virginia's local school systems are the Battelle Developmental Inventory, Learning Accomplishments Profile – Diagnostic Edition (LAP-D), the Early Learning Accomplishment Profile (ELAP), and the Hawaiian Early Learning Profile (HELP). For infants and toddlers born prematurely (gestation period of less than 37 weeks), the child's actual adjusted age is used to determine his or her developmental status. Chronological age is used once the child is 18 months old.

Consumer means a current direct recipient of public or mental health, mental retardation, or substance abuse treatment or habilitation services.

Discharge means the process by which a CSB documents the completion of a person's episode of care, thereby closing the consumer's clinical record. Discharge occurs at the CSB level, as opposed to release from a specific service. When a consumer has completed receiving all services in all services in which he or she was enrolled, the person has completed the current episode of care and is discharged from the CSB. A person is discharged from a CSB if any of the following conditions exists; the consumer has:

1. been determined to need no further services,
2. been released from enrollment at all CSB and CSB-contracted services and discharged in accordance with CSB policies,
3. received no CSB services in 180 days from the date of the last face-to-face contact, except for Consumer Monitoring Services, or has indicated that he no longer desires to receive services, or
4. relocated or died.

Persons may be discharged in less than the maximum time since the last face-to-face contact (i.e., less than 180 days) at the CSB's discretion, but the person must be discharged if no face-to-face services have been received in the maximum allowable time period for that episode of care. Once discharged, should a consumer return for services, that person would be readmitted; the subsequent admission would begin a new episode of care. If the person is discharged because he or she has received no services in 180 days, the discharge date must be the date of the last face-to-face or other contact with the person, not the 180th day.

In the rare circumstance in which services are provided for a consumer after he or she has been discharged (e.g., completing a discharge summary), the units of service should be collected and reported in the core service category or subcategory (e.g., Outpatient or Case Management Services) where the activity occurred using the z-consumer function, a service with no associated consumer, for Community Consumer Submission (CCS) purposes.

Enrollment means the process by which a CSB or CSB-contracted program accepts a person into a service for an identified condition or, for persons with mental retardation, an identified support need. Enrollment implies an intention for the consumer to receive ongoing services under the direction of the consumer's individualized services plan. A person is enrolled in every service that

he or she receives. In some instances, a person may be enrolled in services in more than one program area during an episode of care. For example, an individual with a co-occurring mental illness and substance use disorder might be enrolled in mental health Rehabilitation Services and substance abuse Outpatient Services. In order for an enrollment to occur, the following actions with appropriate documentation are necessary:

1. determination that the person is in need of services available through the CSB or its contract agencies,
2. completion of a psychosocial history (if not fully completed at the time of admission),
3. diagnosis or provisional diagnosis of the consumer's condition, and
4. initiation of the development of an individualized services plan.

Episode of Care means all of the services provided to a consumer to address an identified condition or support need over a continuous period of time between an admission and a discharge. An episode of care begins with an admission to the CSB and an enrollment in an initial service; it may include subsequent enrollments in and releases from other services; and it ends with the last release from a service and discharge from the CSB. An episode of care may consist of a single face-to-face encounter or multiple services provided through one or more programs. For example, a person may be admitted to the CSB and enrolled in the Limited Service of Assessment and Evaluation for a court-ordered evaluation or psychological assessment, the assessment or evaluation is completed the same day, and the person is released from the Assessment And Evaluation Service and discharged from the CSB on that same day. In another case, a person with complex and co-occurring conditions may be admitted to the CSB and enrolled in the most urgently needed service, for example, Emergency Services, on the same day. Subsequently, that person may be released from Emergency Services and enrolled in Assertive Community Treatment. The person continues in that service for several years and then moves to another CSB service area or state. At that point, the person is released from Assertive Community Treatment and discharged from the CSB.

A person is enrolled in and released from every service he or she receives during an episode of care. If a person has been released from his or her last service but not yet discharged and he or she returns for services within 90 days, the person is not admitted, since he or she has not been discharged, the person is merely enrolled in the needed service. In the rare circumstance in which services are provided for a consumer after he or she has been discharged (e.g., completing a discharge summary), the units of service should be collected and reported in the core service category or subcategory (e.g., Outpatient or Case Management Services) where the activity occurred using the z-consumer function, a service with no associated consumer, for Community Consumer Submission (CCS) purposes.

Mental Illness means a disorder of thought, mood, emotion, perception or orientation that significantly impairs judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, recovery, or safety of the individual or for the safety of others.

Serious Mental Illness means a severe and persistent mental or emotional disorder that seriously impairs the functioning of adults, 18 years or age or older, in such primary aspects of daily living as personal relations, self-care skills, living arrangements, or employment. Individuals with serious mental illness who also have been diagnosed as having a substance use disorder or mental retardation are included in this definition. Serious mental illness is defined along three dimensions: diagnosis, level of disability, and duration of illness. All three dimensions must be met to meet the criteria for serious mental illness.

1. Diagnosis: The person must have a major mental disorder diagnosed under the *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV, Fourth Edition). These disorders are: schizophrenia, major affective disorders, paranoia, organic or other psychotic disorders, personality disorders, or other disorders that may lead to chronic disability. A diagnosis of adjustment disorder or a V Code diagnosis cannot be used to satisfy this criterion.
2. Level of Disability: There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. Individuals should meet at least two of the following criteria on a continuing or intermittent basis.
    a. The person is unemployed, is employed in a sheltered setting or a supportive work situation, has markedly limited or reduced employment skills, or has a poor employment history.
    b. The person requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
    c. The person has difficulty establishing or maintaining a personal social support system.
    d. The person requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
    e. The person exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
3. Duration of Illness: The individual is expected to require services of an extended duration, or the individual's treatment history meets at least one of the following criteria.
    a. The individual has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization, more than once in his or her lifetime.
    b. The individual has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

Serious Emotional Disturbance means a serious mental health problem that can be diagnosed under the DSM-IV in a child, age birth through 17, or the child must exhibit all of the following:

1. Problems in personality development and social functioning that have been exhibited over at least one year's time,
2. Problems that are significantly disabling based upon the social functioning of most children of the child's age,
3. Problems that have become more disabling over time, and
4. Service needs that require significant intervention by more than one agency.

At Risk of Serious Emotional Disturbance means for a child, age birth through seven, meeting at least one of the following criteria:

1. The child exhibits behavior or maturity that is significantly different from most children of the child's age and that is not primarily the result of developmental disabilities or mental retardation; or
2. Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavioral problems; or

3. The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, that have put him or her at risk for serious emotional or behavioral problems.

Please refer to Appendix A that contains detailed criteria in checklists for serious mental illness, serious emotional disturbance, and at risk of serious emotional disturbance. Those criteria are congruent with these definitions and will ensure consistent screening for and assessment of these conditions.

Mental Retardation, as defined in the *Code of Virginia,* means a disability originating before the age of 18 years, characterized concurrently by (i) significantly subaverage intellectual functioning as demonstrated by performance on a standardized measure of intellectual functioning, administered in conformity with accepted professional practice, that is at least two standard deviations below the mean and (ii) significant limitations in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.

Program Area means the general classification of service activity for a defined population. The three program areas in the public services system are mental health, mental retardation, and substance abuse services.

Release means the process by which a CSB or CSB-contracted program documents that a consumer has completed receiving services from a particular service in which he or she was enrolled. When this occurs, the consumer is released from that service.

Service Area means the city or county or combination of cities and counties or counties or cities that established and is served by the CSB.

Substance Abuse, as defined in the *Code of Virginia*, means the use of drugs, enumerated in the Virginia Drug Control Act (§ 54.01-3400 et seq.), without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care. Substance abuse is now beginning to be defined and described as substance use disorder. There are two levels of substance use disorder: substance addiction (dependence) and substance abuse.

Substance Addiction (Dependence), as defined by ICD-9, means uncontrollable substance-seeking behavior involving compulsive use of high doses of one or more substances resulting in substantial impairment of functioning and health. Tolerance and withdrawal are characteristics associated with dependence. ICD-9 defines substance dependence as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. tolerance, as defined by a need for markedly increased amounts of the substance to achieve intoxification or desired effect or markedly diminished effect with continued use of the same amount of the substance;
2. withdrawal, as manifested by the characteristic withdrawal syndrome for the substance or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
3. the substance is often taken in larger amounts or over a longer period than was intended;

4. there is a persistent desire or unsuccessful efforts to cut down or control substance use;
5. a great deal of time is spent on activities necessary to obtain the substance, use the substance, or recover from its effects;
6. important social, occupational, or recreational activities are given up or reduced because of substance use; and
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Substance Abuse, as defined by ICD-9, means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. It leads to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);
2. recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
3. recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); and
4. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxification, physical fights).

Appendix A: Serious Mental Illness Criteria Checklist

SERIOUS MENTAL ILLNESS CRITERIA CHECKLIST		
YES	**NO**	**CRITERIA**
		1. AGE: The person is 18 years of age or older.
		2. DIAGNOSIS: The person has a major mental disorder diagnosed under the DSM IV. **At least one of the following diagnoses must be present.** Adjustment disorder or V Code diagnoses do not meet this criterion.
		Schizophrenia, all types
		Major Affective Disorder
		Paranoid Disorder
		Organic Disorder
		Other Psychotic Disorder
		Personality Disorder
		Other Mental Health Disorder that may lead to chronic disability
		3. LEVEL OF DISABILITY: There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. **The person must meet at least two of these criteria on a continuing or intermittent basis. The person:**
		Is unemployed; employed in a sheltered setting or a supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history.
		Requires public financial assistance to remain in the community and may be unable to procure such assistance without help.
		Has difficulty establishing or maintaining a personal social support system.
		Requires assistance in basic living skills such as personal hygiene, food preparation, or money management.
		Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system.
		4. DURATION OF ILLNESS: The person must meet at least one of these criteria. The person:
		Is expected to require services of an extended duration.
		Has undergone psychiatric treatment more intensive than outpatient care, such as crisis response services, alternative home care, partial hospitalization, or inpatient hospitalization, more than once in his or her lifetime.
		Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.
		If YES is checked for criterion 1, and for at least one response in criterion 2, and for at least two responses in criterion 3, and for at least one response in criterion 4, then check **YES** here to indicate that the person has serious mental illness.
NOTE: Any diagnosis checked in 2 above must be documented in the person's clinical record and in the CSB's information system, and the person's clinical record also must contain documentation that he or she meets any criteria checked in 3 and 4 above.		

Appendix A: Serious Emotional Disturbance Criteria Checklist

SERIOUS EMOTIONAL DISTURBANCE CRITERIA CHECKLIST		
YES	**NO**	**CRITERIA**
		1. AGE: The person is a child, age birth through 17.
		2. DIAGNOSIS: The child has a serious mental health problem that can be diagnosed under the DSM IV. Specify the diagnosis: _____
		3. PROBLEMS AND NEEDS: The child must exhibit all of the following:
		Problems in personality development and social functioning that have been exhibited over at least one year's time,
		Problems that are significantly disabling based upon the social functioning of most children of the child's age,
		Problems that have become more disabling over time, and
		Service needs that require significant intervention by more than one agency.
		If YES is checked for criterion 1 and for criterion 2 **OR** for all four responses in criterion 3, then check **YES** here to indicate that the child has serious emotional disturbance.
NOTE: Any diagnosis in criterion 2 above must be documented in the child's clinical record and in the CSB's information system, and the child's clinical record also must contain documentation of any of the problems or needs checked in criterion 3 above.		

Appendix A: At Risk of Serious Emotional Disturbance Criteria Checklist

AT RISK OF SERIOUS EMOTIONAL DISTURBANCE CRITERIA CHECKLIST		
YES	**NO**	**CRITERIA**
		1. AGE: The person is a child, age birth through 7.
		2. PROBLEMS: The child must meet at least one of the following criteria.
		The child exhibits behavior or maturity that is significantly different from most children of the child's age and that is not primarily the result of developmental disabilities or mental retardation; or
		Parents or persons responsible for the child's care have predisposing factors themselves, such as inadequate parenting skills, substance use disorder, mental illness, or other emotional difficulties, that could result in the child developing serious emotional or behavioral problems; or
		The child has experienced physical or psychological stressors, such as living in poverty, parental neglect, or physical or emotional abuse, that have put him or her at risk for serious emotional or behavioral problems.
		If YES is checked for criterion 1 and for any problem in criterion 2, then check **YES** here to indicate that the child is at risk of serious emotional disturbance.
NOTES: These criteria should be used only if the child does not have serious emotional disturbance. The child's clinical record must contain documentation of any of the problems checked in criterion 2 above.		

Appendix B: Core Services Taxonomy and Medicaid Mental Retardation Home and Community-Based Waiver Services Crosswalk

Core Services Taxonomy Service	MR Home and Community-Based Waiver Service
Emergency Services	Crisis Stabilization Personal Emergency Response System [1]
Inpatient Services	None
Outpatient Services	Skilled Nursing Services [2] Therapeutic Consultation [3]
Case Management Services	None. Case Management is not a Waiver service.
Day Support: Habilitation	Day Support (Center-Based and Non-Center-Based) Prevocational
Employment: Sheltered Employment	None
Employment: Group Supported Employment	Supported Employment – Group Model
Employment: Individual Supported Employment	Supported Employment - Individual Placement
Highly Intensive Residential Services	None, this is ICF/MR services in the Taxonomy.
Intensive Residential Services	Congregate Residential Support Services [5]
Supervised Residential Services	Congregate Residential Support Services [5]
Supportive Residential Services	Supported Living/In-Home Residential Supports Respite Services (Agency and Consumer-Directed) Personal Assistance Services (Agency and Consumer-Directed) [4] Companion Services (Agency and Consumer-Directed)
Early Intervention	None
Limited Services	None

This crosswalk is included for information purposes. When there is an inconsistency between Medicaid service units and taxonomy units of service, taxonomy units of service will be used for performance contract, uniform cost report, and community consumer submission purposes.

[1] **Personal Emergency Response System** will be counted in the taxonomy and performance contract in terms of numbers of consumers served and expenses; there are no taxonomy units of service for this Medicaid service.

[2] **Skilled Nursing Services** are available to consumers with serious medical conditions and complex health care needs that require specific skilled nursing services that are long term and maintenance in nature ordered by a physician and ***which cannot be accessed under the Medicaid State Plan***, which offers short-term skilled nursing services (up to 32 visits without preauthorization, with additional visits preauthorized) under Home Health Services. Services are provided in the consumer's home or a community setting on a regularly scheduled or intermittent need basis. The Medicaid service unit is one hour.

[3] **Therapeutic Consultation** provides expertise, training, and technical assistance in a specialty area (psychology, behavioral consultation, therapeutic recreation, rehabilitation engineering, speech therapy, occupational therapy, or physical therapy) to assist family members, care givers, and

other service providers in supporting the consumer. MR Waiver therapeutic consultation services may not include direct therapy provided to Waiver consumers or duplicate the activities of other services available to the person through the State Plan for Medical Assistance. This service may not be billed solely for monitoring purposes. The Medicaid service unit is one hour. Therapeutic Consultation is included under outpatient services in the crosswalk, instead of Case Management Services, to preserve the unique nature of case management services and because it seemed to fit most easily in Outpatient Services. This also is the preference expressed by the MR Council.

[4] **Personal Assistance Services** are available to MR Waiver consumers who do not receive congregate residential support services or live in an assisted living facility and for whom training and skills development are not primary objectives or are received in another service or program. Personal assistance means direct assistance with personal care, activities of daily living, medication or other medical needs, and monitoring physical condition. It may be provided in residential or non-residential settings to enable a consumer to maintain health status and functional skills necessary to live in the community or participate in community activities. Personal assistance services may not be provided during the same hours as Waiver supported employment or day support, although limited exceptions may be requested for individuals with severe physical disabilities who participate in supported employment. The Medicaid service unit is one hour. Personal Assistance Services and Companion Services are included under Supportive Residential Services because they are more residentially based than day support based. The credentials for both include Department residential services licenses. This is the preference expressed by the MR Council. The Medicaid service unit and taxonomy unit are the same, a provider service hour.

[5] **Congregate Residential Support Services** have a Medicaid service unit measured in hours; this is inconsistent with the taxonomy bed day unit of service for Intensive and Supervised Residential Services. Therefore, Congregate Residential Support Services will be counted in the taxonomy and performance contract in terms of numbers of consumers served and expenses; there are no taxonomy units of service for these Medicaid services.

Environmental Modifications are available to consumers who are receiving at least one other MR Waiver service along with Medicaid targeted case management services. Modifications are provided as needed only for situations of direct medical or remedial benefit to the consumer. These are provided primarily in a consumer's home or other community residence. Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. Environmental modifications include physical adaptations to a house or place of residence necessary to ensure a consumer's health or safety or to enable the consumer to live in a non-institutional setting, environmental modifications to a work site that exceed reasonable accommodation requirements of the Americans with Disabilities Act, and modifications to the primary vehicle being used by the individual. The Medicaid service unit is hourly for rehabilitation engineering, individually contracted for building contractors, and may include supplies. Environmental Modifications are included in the core service in which they are implemented (e.g., various Residential Services, Case Management Services).

Assistive Technology is available to consumers who are receiving at least one other MR Waiver service along with Medicaid targeted case management services. It includes specialized medical equipment, supplies, devices, controls, and appliances not available under the State Plan for Medical Assistance that enable individuals to increase their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live or that are necessary to their proper functioning. It may be provided in a residential or non-residential setting. The Medicaid service unit is hourly for rehabilitation engineering or the total cost of the item or the supplies. Assistive Technology is included in the core service in which it is implemented (e.g., various Residential Services, Case Management Services).

Appendix C: Medicaid Mental Retardation Home and Community-Based Waiver Service Definitions

These condensed Medicaid definitions are appended to the taxonomy for information and reference purposes only. Complete official definitions can be found in the Mental Retardation Community Services Manual, issued by the Department of Medical Assistance Services (DMAS) and available at www.dmas.virginia.gov. DMAS may revise service definitions at any time. Service units in the following definitions are Medicaid units. In some instances, taxonomy service unit definitions are intentionally not consistent with these Medicaid service unit definitions. In those situations, the taxonomy service unit usually is smaller and can be aggregated up to the Medicaid service unit.

Assistive Technology

Assistive Technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the *State Plan for Medical Assistance (SPMA)*, that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning. Equipment and activities include:

1. Specialized medical equipment, ancillary equipment, and supplies necessary for life support not available under the *SPMA;*
2. Durable or non-durable medical equipment and supplies (DME) not available under the *SPMA*;
3. Adaptive devices, appliances, and controls not available under the *SPMA* that enable an individual to be more independent in areas of personal care and activities of daily living; and
4. Equipment and devices not available under the *SPMA* that enable an individual to communicate more effectively.

Medicaid Service Units and Service Limitations

The service unit for items and supplies is the total cost of the item and any supplies. The service unit for Rehabilitation Engineering is hourly. The maximum Medicaid funded expenditure for Assistive Technology is $5,000.00 per CSP year. The cost for Assistive Technology cannot be carried over from one CSP year to the next and must be preauthorized each CSP year.

Companion Services (Agency-Directed)

Companion services provide non-medical care, socialization, or support to adults in an individual's home or at various locations in the community. Allowable activities include:

1. Assistance or support with tasks such as meal preparation, laundry and shopping;
2. Assistance with light housekeeping tasks;
3. Assistance with self-administration of medication;
4. Assistance or support with community access and recreational activities; and
5. Support to assure the safety of the individual.

Medicaid Service Units and Service Limitations

Companion services must be billed on an hourly basis. The amount of Companion services time included in the CSP may not exceed eight hours per 24-hour day.

Companion Services (Consumer-Directed)

Companion services provide non-medical care, socialization or support to adults in an individual's home or at various locations in the community. Allowable activities are the same as agency-directed Companion Services. The distinction between the two services is that the individual,

family member or caregiver is the employer and is responsible for hiring, training, supervising, and firing companions in consumer-directed services.

Medicaid Service Units and Service Limitations

Companions are paid an hourly rate. The Fiscal Agent pays a companion on behalf of the individual once the timesheet is signed by the companion and the individual and forwarded to the Fiscal Agent. Companion services must be billed on an hourly basis. The amount of Companion Services time included in the ISP may not exceed eight hours per 24-hour day.

Crisis Stabilization Services

Crisis Stabilization is direct intervention (and may include one-to-one supervision) to persons with mental retardation who are experiencing serious psychiatric or behavioral problems which jeopardize their current community living situation. The goal is to provide temporary intensive services and supports to avert emergency psychiatric hospitalization or institutional admission or to prevent other out-of-home placement. The intent is to stabilize the individual and to strengthen the current living situation so the individual can be maintained during and beyond the crisis period. Allowable activities include:

1. Psychiatric, neuropsychiatric, and psychological assessment, and other functional assessments and stabilization techniques;
2. Medication management and monitoring;
3. Behavior assessment and positive behavior support;
4. Intensive care coordination with other agencies and providers to assist the planning and delivery of services and supports to maintain community placement of the individual;
5. Training of family members and other caregivers and service providers in positive behavioral supports to maintain the individual in the community; and
6. Temporary Crisis Supervision (as a separate billable service) to ensure the safety of the individual and others.

Medicaid Service Units and Service Limitations

Mental Retardation Crisis Stabilization Clinical or Behavioral services are billed in hourly service units and may be authorized for provision during a maximum of 15 days. Service can be provided no more than 60 days in a calendar year. Crisis Supervision, if provided within the authorized period as a component of this service, is separately billed in hourly service units.

Day Support

Day Support services include training, assistance or specialized supervision for the acquisition, retention or improvement in self-help, socialization and adaptive skills. It allows peer interactions and an opportunity for community and social integration. Specialized supervision provides staff presence for ongoing or intermittent intervention to ensure an individual's health and safety. These services typically take place in non-residential settings, separate from the home or facility in which the individual resides. Day Support services focus on enabling the individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational, or speech/language therapies listed in the CSP. In addition, day support services may serve to reinforce skills or lessons taught in school, therapy or other settings. Services are normally furnished one or more hours per day on a regularly scheduled basis for one or more days per week. Allowable services include:

1. Functional training in self, social, and environmental awareness skills;
2. Functional training in sensory stimulation and gross and fine motor skills;
3. Functional training in communication and personal care;

4. Functional training in the use of community resources, community safety, appropriate peer interactions, and social skills;
5. Functional training in learning and problem-solving skills;
6. Functional training in adapting behavior to social and community settings;
7. Assistance with personal care and use of community resources;
8. Supervision to ensure the individual's health and safety;
9. Staff coverage for transportation of the individual between training and service activity sites; and
10. Opportunities to use functional skills in community settings.

Types and Levels of Day Support

The amount and type of Day Support included in the individual's CSP is determined according to the level of staff involvement required for that individual. There are two types of Day Support: Center-based, which is provided primarily in a single location with other individuals with disabilities, and Non-center-based, which is provided primarily in community settings. Non-center-based Day Support services must be separate and distinguishable from Residential Support or Personal Assistance services. There must be separate, supporting documentation for each service and each must be clearly differentiated in documentation and corresponding billing. Both types of Day Support may be provided at Intensive or Regular Levels. To be authorized at the Intensive Level, the individual must meet at least one of the following criteria:

- Requires physical assistance to meet basic personal care needs (toileting, feeding, etc.);
- Has extensive disability-related difficulties and requires additional, ongoing support to fully participate in programming and to accomplish individual service goals; or
- Requires extensive personal care or constant supports to reduce or eliminate behaviors that preclude full participation in the program. A written behavioral objective in the ISP is required to address behaviors such as, but not limited to, withdrawal, self-injury, aggression, or self-stimulation.

Medicaid Service Units and Service Limitations

Billing is for a unit of service:

- One unit is 1 to 3.99 hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25 percent of the total time spent in the Day Support activity for that day.
- Two units are 4 to 6.99 hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25 percent of the total time spent in the Day Support activity for that day; and
- Three units are 7 or more hours of service per day. In instances where staff are required to ride with the individual to and from Day Support activities, billing for this time cannot exceed 25 percent of the total time spent in the Day Support activity for that day; however, a minimum of 7 hours of other allowable activities must be provided in order to be reimbursed for a 3-unit day.

The ISP must provide an estimate of the amount of Day Support required by the individual. The maximum is 780 units per consumer service plan (CSP) year.

Environmental Modifications

Environmental Modifications are physical adaptations to a person's home or community residence, vehicle, and, in some instances, workplace that provide direct medical or remedial benefit to him or her. These adaptations are necessary to ensure the health, welfare, and safety of the individual or enable the person to function with greater independence in the home or work site. Without these adaptations, the individual would require institutionalization. Modifications and activities are:

1. Physical adaptations to a house or place of residence necessary to ensure an individual's health, welfare, and safety (e.g., installation of specialized electric and plumbing systems to accommodate medical equipment and supplies);
2. Physical adaptations to a house or place of residence that enable an individual to live in a non-institutional setting and to function with greater independence but do not increase the square footage of the house or place of residence (e.g., installation of ramps and grab-bars, widening of doorways, modifications of bathroom facilities);
3. Environmental modifications to the work site that exceed reasonable accommodation requirements of the employer under the Americans with Disabilities Act; and
4. Modifications to the primary vehicle being used by the individual.

Medicaid Service Units and Service Limitations

The service unit for Rehabilitation Engineering is hourly. Building contractor services are individually contracted for and may include supplies or the total cost of supplies may be billed separately. The maximum Medicaid-funded expenditure for environmental modifications is $5,000.00 per CSP year. Costs for environmental modifications cannot be carried over from one CSP year to the next, and must be pre-authorized each CSP year. Environmental modifications may not be used to bring a substandard dwelling up to minimum habitation standards.

Personal Assistance Services (Agency-Directed)

Personal Assistance services mean direct support with personal assistance, activities of daily living, community access, medication and other medical needs, and monitoring health status and physical condition. These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Allowable activities include:

1. Assistance with activities of daily living (ADLs), such as: bathing or showering, toileting, routine personal hygiene skills, dressing, and transferring;
2. Assistance with monitoring health status and physical condition;
3. Assistance with medication and other medical needs;
4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);
5. Assistance with housekeeping activities, such as bed making, dusting, vacuuming, laundry, and grocery shopping, when specified in the individual's ISP and essential to the individual's health or welfare or both;
6. General support to assure the safety of the individual;
7. Assistance and support needed by the individual to participate in social, recreational, and community activities; and
8. Accompanying the individual to appointments or meetings.

Medicaid Service Units and Service Limitations

The unit of service for Personal Assistance services is one hour. The amount of Personal Assistance services that can be authorized is determined by the individual's assessed needs and required supports. When two individuals who live in the same home request Personal Assistance services, the provider will assess the needs of all authorized individuals independently and determine the amount of time required for each individual for those tasks that must be provided independently, such as bathing, dressing, and ambulating. The amount of time for tasks that could and should be provided for both individuals simultaneously (such as meal preparation, cleaning rooms, laundry, and shopping) must be combined and the hours split between the individuals.

Personal Assistance Services (Consumer-Directed)

Consumer Directed Personal Assistance (CD-PA) services mean direct assistance with personal care activities of daily living, access to the community, medication and other medical needs and monitoring health status and physical condition. The distinction between CD-PA and agency-directed Personal Assistance is that the individual, family member or caregiver is the employer and is responsible for hiring, training, supervising, and firing assistants in CD-PA. When specified, supportive services may include assistance with instrumental activities of daily living (IADLs) that are incidental to the Personal Assistance services furnished or which are essential to the health and welfare of the individual. CD-PA services shall not include practical or professional nursing services as defined in the Nurse Practice Act. CD-PA services may be provided in the home or community settings to enable an individual to maintain the health status and functional skills necessary to live in the community or participate in community activities. Allowable activities are the same as agency-directed Personal Assistance services, plus:

- Assistance with bowel and bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care;
- Attending training requested by the individual, family member or caregiver that relates to services described in the CSP; and
- Assistance in the workplace with activities not already required or funded by another source (may include activities such as assistance with filing, retrieving work materials that are out of reach; providing travel assistance for an individual with a mobility impairment; helping an individual with organizational skills; reading handwritten mail to an individual with a visual impairment; or ensuring that a sign language interpreter is present during staff meetings to accommodate an employee with a hearing impairment).

Medicaid Service Units and Service Limitations

Personal assistants are paid an hourly rate. The Fiscal Agent pays personal assistants on behalf of the individual once the timesheet is signed by the assistant and individual and forwarded to the Agent.

Personal Emergency Response System

Personal Emergency Response System (PERS) is an electronic device that enables certain individuals to secure help in an emergency. PERS electronically monitors individual safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individual's home telephone line. When appropriate, PERS may also include medication monitoring devices. PERS services are limited to those individuals who live alone or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, and would otherwise require extensive routine supervision. Medication monitoring units must be physician-ordered and are not considered a stand-alone service. Individuals must be receiving PERS services and medication monitoring services simultaneously. PERS can only be authorized when no one else is in the home who is competent or continuously available to call for help in an emergency.

Medicaid Service Units and Service Limitations

A unit of service shall include administrative costs, time, labor, and supplies associated with the installation, maintenance, and monitoring of the PERS. A unit of service is one-month rental price set by DMAS. The one time installation of the unit(s) shall include installation, account activation, individual and caregiver instruction, and removal of equipment.

Prevocational

Prevocational services are aimed at preparing an individual for paid or unpaid employment, but are not job task-oriented. They are aimed at a more generalized result. Prevocational services are provided to individuals who are not expected to join the regular work force without supports or participate in a transitional sheltered workshop program within a year (excluding supported employment programs). Prevocational services may be provided in sheltered workshop settings. Allowable activities include:

1. Training and support in skills that are aimed at preparation for paid employment offered in a variety of community settings;
2. Training and support in activities that are primarily directed at habilitative goals (e.g., attention span and motor skills);
3. Training and support in such concepts as accepting supervision, attendance, task completion, problem solving, and safety;
4. Training and support that is focused on completing assignments, solving problems, or safety;
5. Assistance with personal care;
6. Supervision to ensure the individual's health and safety; and
7. Staff coverage for transportation of the individual between training and service activity sites.

Medicaid Service Units and Service Limitations

Billing is for a unit of service. The unit structure and parameters are the same as for Day Support. The ISP must provide an estimate of the amount of Prevocational required by the individual. The maximum is 780 units per consumer service plan (CSP) year.

Residential Support Services

Residential Support services consist of training and assistance or specialized supervision, provided primarily in an individual's home or in a licensed or approved residence considered to be his or her home, to enable the individual to acquire, improve, or maintain his or her health status and to develop skills in activities of daily living and safety in the use of community resources and adapting his or her behavior to community and home environments. Emphasis is on a person-centered approach that empowers and supports each individual in developing his or her own lifestyle. Residential Support may not include room and board or general supervision. MR Waiver services will not be routinely provided for a continuous 24-hour period. Residential Support services may be provided as Supported Living/In-Home Supports or as Congregate Residential Support. The distinction is based on the service setting that provides the services, the ratio of staff to individuals, and whether services are routinely provided by paid staff across a continuous 24-hour period.

Supported Living/In-Home Supports are supplemental to the primary care (i.e., room and board or general supervision) provided by a parent or similar caregiver. This service may also support an individual whose level of independence does not require a primary care provider. The usual setting is a private residence, such as a home or apartment. A Residential Support staff person comes to the residence to provide services. Supported Living/In-Home Supports are delivered on an individualized basis according to the ISP and are delivered primarily with a 1:1 staff-to-individual ratio except when training protocols require parallel or interactive intervention. Primary care and Residential Support services are not routinely provided by paid staff of the Supported Living/In-Home Supports provider across a continuous 24-hour period.

Congregate Residential Support is training, assistance and specialized supervision provided to an individual living in a group home, the home of the care provider who also provides the MR Waiver services (such as Adult Foster Care or Sponsored Placement), or an apartment or other home setting, with one or more individuals also receiving MR Waiver Residential Support services from

the same staff at the same time, and delivered according to the CSP, including individual or group situations.

Medicaid Service Units and Service Limitations

Congregate Residential Support may be reimbursed on an average daily amount of hours established per individual. The average daily amount is determined by multiplying the total hours scheduled per week by 4.3 and dividing the results by 30. The average daily amount is used for billing purposes only. Whenever *any portion* of the training, assistance, or specialized supervision authorized in the Residential Support CSP is provided during a day, the entire average daily amount of hours may be billed. No more than 30 days per month (28/29 days in February) may be billed when billing is based on the average daily amount. Supported Living/In-Home Supports are reimbursed on an hourly basis for the time the Residential Support staff is working directly with the individual. Total billing cannot exceed the total hours authorized by the ISAR. When unavoidable circumstances occur so that a provider is at the individual's home at the designated time but cannot deliver part of the services due to individual or family related situations (such as unanticipated lateness or illness of the individual or family emergency), billing will be allowed for the *entire* number of hours scheduled for that day, as long as *some portion* of the CSP is provided.

Respite Services (Agency-Directed)

Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary caregiver. They are provided in an individual's home, other community residence or in other community sites. Allowable activities include:

1. Assistance with activities of daily living such as: bathing or showering, toileting, routine personal hygiene skills, dressing, and transferring;
2. Assistance with monitoring health status and physical condition;
3. Assistance with medication and other medical needs;
4. Assistance with preparation and eating of meals (preparation only of the individual's meal is allowed);
5. Assistance with housekeeping activities, such as bed-making, dusting and vacuuming, laundry, and grocery shopping, when specified in the individual's CSP and essential to the individual health and welfare;
6. Support to assure the safety of the individual;
7. Assistance or support, or both, needed by the individual to participate in social, recreational, or community activities; and
8. Accompanying the individual to appointments or meetings.

Medicaid Service Units and Service Limitations

The unit of service for Respite services is one hour. Respite services provided in any setting are limited to 720 hours per calendar year. Individuals who are receiving both consumer-directed and agency-directed Respite services cannot exceed 720 hours per calendar year combined.

Respite Services (Consumer-Directed)

Consumer-Directed (CD) Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. These services are provided on a short-term basis because of the emergency absence or need for periodic or routine relief of the primary caregiver. They are provided in an individual's home, other community residence, and other community sites. The distinction between CD-Respite and agency-directed Respite services is that the individual, family member or caregiver is the

employer and is responsible for hiring, training, supervising, and firing respite assistants in CD-Respite services. Allowable activities are the same as agency-directed Respite services, plus:

- Assistance with bowel and bladder programs, range of motion exercises, routine wound care that does not include sterile technique, and external catheter care; and
- Attending training requested by the individual, family member or caregiver that relates to services described in the CSP.

Medicaid Service Units and Service Limitations

Respite assistants are paid an hourly rate. Respite services provided in any setting are limited to 720 hours per calendar year. Individuals who are receiving consumer-directed and agency-directed Respite services cannot exceed 720 hours per calendar year combined. The Fiscal Agent pays respite assistants on behalf of the individual, once the timesheet is signed by the assistant and individual and forwarded to the Agent.

Skilled Nursing Services

Skilled nursing services are available to individuals with serious medical conditions and complex health care needs, which require specific skilled nursing services ordered by a physician and which cannot be accessed under the *State Plan for Medical Assistance*. These services must be necessary to enable an individual to live in a non-institutional setting in the community and cannot be provided by non-nursing personnel. Services are provided in an individual's home or community setting, or both, on a regularly scheduled or intermittent need basis. Allowable activities include:

1. Monitoring of an individual's medical status;
2. Administering medications and other medical treatment; or
3. Training or consultation with family members, staff, and other persons responsible for carrying out an individual's CSP to monitor the individual's medical status and to administer medications and other medically related procedures consistent with the Nurse Practice Act (Title 54.1, Code of Virginia, Subtitle III, Chapters 30 and 34).

Medicaid Service Units and Service Limitations

The unit of service is one hour, with no limitation on the number of hours that may be authorized. However, the Skilled Nursing services must be explicitly detailed in an ISP and must be specifically ordered by a physician as medically necessary to prevent or delay institutionalization.

Supported Employment

Supported Employment means work in settings in which persons without disabilities are typically employed. It is especially designed for individuals with developmental disabilities, including persons with mental retardation, facing severe impediments to employment due to the nature and complexity of their disabilities, irrespective of age or vocational potential. Supported employment services are available to individuals for whom competitive employment at or above the minimum wage is unlikely without on-going supports and who because of their disability, need ongoing post-employment support to perform in a work setting.

Models of Supported Employment

Supported Employment can be provided in one of two models. Individual Supported Employment is defined as intermittent support, usually provided one-on-one by a job coach to an individual in a supported employment position who, during most of the time on the job site, performs independently. Group Supported Employment is defined as continuous support provided by staff to eight or fewer individuals with disabilities in an Enclave, Work Crew, Entrepreneurial model or Benchwork model. An Entrepreneurial model of Supported Employment is a small business

employing fewer than eight individuals with disabilities and usually involves interactions with the public and with co-workers without disabilities. An example of the Benchwork model is a small, nonprofit electronics assembly business that employs individuals without disabilities to work alongside eight or fewer individuals with significantly complex needs and provides daily opportunities for community integration. The individual's assessment and CSP must clearly reflect the individual's need for training and supports to acquire or maintain paid employment.

Medicaid Service Units and Service Limitations

Supported Employment for individual job placement will be billed on an hourly basis. It may include transportation of the person to and from work sites, not to exceed 25 percent of the total time billed.
Group models of Supported Employment (Enclaves, Work Crews, Entrepreneurial and Benchwork models of Supported Employment) will be billed according to the same units of service as Day Support.

Therapeutic Consultation

Therapeutic Consultation provides expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual. The specialty areas are:

1. Psychology;
2. Behavioral Consultation;
3. Therapeutic Recreation;
4. Speech and Language Pathology;
5. Occupational Therapy;
6. Physical Therapy; and
7. Rehabilitation Engineering.

Medicaid Service Units and Service Limitations

The unit of service is one hour, with no limitation on the number of hours that may be authorized. However, the services must be explicitly detailed in an CSP. Travel time, written preparation, and telephone communication are in-kind expenses within this service and are not billable as separate items. Therapeutic Consultation may not be billed solely for purposes of monitoring.